` ' '			SUBJECT (Document Title)				
Health Care Manag	gemei	nt_ Utilizatio	า	Health	Care Manageme	nt De	nial Core
Management				Proces	s LA		
Effective Date		Date of Last F	Review	Date o	f Last Revision	Dep	t. Approval Date
December 16, 2009	9	August 1, 201	9	August	· 1,	Aug	ust 1,
				2019 D	ecember 26,	2019	December 26,
				2019		2019	<u>9</u>
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<u>Products</u>	☐ Arka	ansas	☐ Indiana		☐ Nevada		☐ Tennessee
Medicaid	☐ Cali	fornia	☐ Iowa		☐ New Jersey		☐ Texas
☐ Medicare/SNP		rado	☐ Kentuck	у	☐ New York – Empire		☐ Virginia
☐ MMP/Duals	☐ Dist	rict of Columbia	□ Louisian	a	☐ New York (WNY)		☐ Washington
	☐ Flor	ida	☐ Marylan	d	☐ North Carolina		☐ Wisconsin
	☐ Geo	rgia	☐ Minneso	ota	\square South Carolina		☐ West Virginia

POLICY:

This procedure is designed to ensure timely utilization decisions which accommodate the clinical urgency and necessity of a situation.

To ensure timely utilization decisions which accommodate the clinical urgency and necessity of a situation.

Healthy Blue makes adverse benefit determinations only as provided for in its contractual agreement and in accordance with state and federal law and regulation. Upon making such determinations, Healthy Blue provides all notices and opportunities for grievance and appeals required contractually or by state and federal law or regulation.

Healthy Blue ensures members receive notices of adverse benefit determinations per 42 CFR 438.915(b) and other requirements which extend notice requirements beyond denials. All determination of action notices must be in writing and must meet the language and format requirements of the Contract and 42 CFR §438.10 (c) and (d) and Section 12 of the State contract to ensure ease of understanding. All action notices are must be completed within compliance with the the State contractual, Balanced Budget Act (BBA), or National Committee for Quality Assurance (NCQA), and contractual timeline guidelines.

The Health Plan shall have the authority to implement their individualized clinical submission deadlines for Concurrent Review. The MCO imposes a specific deadline (i.e. 4:00 p.m. CST) for a length of stay extension request, concurrent review clinical submission, the Health Plan's Provider Handbook should indicate this deadline.

For monitoring compliance with the Healthy Blue contract, the LDH will continue to audit Health Plans compliance with Concurrent Review turnaround times in accordance with the terms and conditions of the contract with the LDH. In reviewing the Health Plan's documentation for compliance for concurrent review, LDH shall review based on the following guidelines:

 It is the Providers responsibility to submit clinical information for review by the specified "Next Review" date and time specified by the Health Plan. If the "Next Review" date

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notification received is a past date, "retrospective", or the same day of receipt, providers have until the specified deadline on the next business day to submit.

- 2) Plans have implemented a ten (10) minute grace period to alleviate time discrepancies on fax and voicemail machines. Proof of a fax confirmation for the transmittal of documentation prior to specified time, has been accepted by the Plan as meeting the deadline.
- 3) If clinical information is not submitted to the Health Plan within the required timeframe, the length of stay extension can be denied. Receipt of administrative denial is based on timely notification not medical necessity.
- 4) Upon receipt of this denial, Providers have until the Health Plan's specified time the next business day to submit clinical information for the days following the denied day to be considered for medical necessity and minimize additional denials. In some cases, notification and/or initial clinical is sent on the day of discharge and sometimes after discharge. These cases do not fall into the concurrent review category. They fall into the category of post service authorization as the services have already been provided and the Health Plan has no ability to impact the stay. The turnaround time for post service authorization specified in the contract is thirty (30) days.

The Health Plan shall not deny continuation of higher level services (e.g., inpatient hospital) for failure to meet medical necessity unless The Health Plan can provide the service through an innetwork or out-of-network provider for a lower lever care.

Timing of Notice

Adverse

The MCO shall notify the member, in writing using language that is easily understood by the member, of decisions to deny a service authorization request, to authorize a service in an amount, duration, or scope that is less than requested, and/or any other action as defined in Section 13 of this RFP. The notice of action to members shall be consistent with requirements in 42 CFR §438.404 and 42 CFR §438.210, Section 12 of this RFP for member written materials, and any agreements that the Department may have entered into relative to the contents of member notices of denial or partial denial of services, regardless of whether such agreements are related to legal proceedings or out-of-court settlements.

The MCO shall notify the requesting provider of a decision to deny an authorization request or to authorize a service in an amount, duration, or scope that is less than requested. The MCO shall notify the notify the provider rendering the service, whether a health care professional or facility or both, verbally or as expeditiously as the member's health condition requires but not more than one (1) business day of making the initial determination and shall provide documented confirmation of such notification to the provider within two (2) business days of making the initial certification.

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The MCO is prohibited from denying prior authorization solely on the basis of the provider being an out of network provider for the first thirty (30) days of a newly enrolled member's linkage to the plan.

The MCO may require notification by the provider of Obstetrical admissions exceeding forty-eight (48) hrs. after a vaginal delivery and ninety-six (96) hours after a Caesarean section. The health plan is allowed to deny a portion of the claim for payment based solely on lack of notification by the provider for both vaginal deliveries exceeding forty-eight (48) hours and Caesarean sections exceeding ninety-six (96) hours. In these cases the health plan is allowed to deny only the portion of the claim related to the inpatient stay beyond forty-eight (48) hours for a vaginal delivery and beyond ninety-six (96) hours for a Caesarean section delivery.

The MCO may require notification by the provider of IP ER admissions within (1) business day of admission.

Administrative Denial Code DD02 Late Notification of Admission will be utilized for both lack of notification of admissions and/or Lack of timely receipt of clinicals after 3:10 p.m.

A member, or a provider on Member's behalf, may appeal prior authorization denials in accordance with Section 13 (Grievances and Appeals) of this contract.

Reconsiderations:

- The designated health plan HCM representative reviews the request and determines if the reconsideration is appropriate (i.e. the request for the reconsideration is within five (5) business days from the issuance of the notice of denial via the health plan fax log.)
 -)—If the request is outside of the appropriate timeframe the physician is instructed to follow the appeals process as indicated within the notice of proposed action letter and documents in the claims payment system.

1) Informal Reconsideration

- As part of the MCO appeal procedures, the MCO should include an Informal Reconsideration process that allows the member (or provider/agent on behalf of a member) a reasonable opportunity to present evidence, and allegations of fact or law, in person as well as in writing.
-) In a case involving an initial determination or a concurrent review determination, the MCO should provide the member or a provider acting on behalf of the member and with the member's written consent an opportunity to request an informal reconsideration of an adverse determination by the physician or clinical peer making the adverse determination [§438.402(b)(ii)].
- The informal reconsideration should occur within one (1) working day of the receipt of the request and should be conducted between the provider rendering

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the service and the MCO's physician authorized to make adverse determinations or a clinical peer designated by the medical director if the physician who made the adverse determination cannot be available within one (1) working day

- Reconsideration discussions must be completed within ten (10) total business days from the first issuance of the fax denial notification. This includes the scheduling and completion of the reconsideration.
-)—If the provider is unable to accept or schedule a discussion within this timeframe the request for reconsideration will be closed and the next course of action for the provider will be the appeal process.
- Reconsiderations are conducted by the member's physician and the health plan Medical Director making the initial determination (or appropriate physician under the direction of the health plan Medical Director if the original health plan Medical Director is not available). The health plan Medical Director completes the reconsideration review with the requesting physician. The Informal Reconsideration will in no way extend the sixty (60) day required timeframe for an Appeal.

In addition to what is outlined in this policy, all written notifications of an action must also include:

. The MCO shall have written procedures to address the failure or inability of a provider or member to provide all the necessary information for review. In cases where the provider or member will not release necessary information, the MCO may deny authorization of the requested service(s) within two (2) business days.

Give members any reasonable assistance in completing forms and taking other procedural steps. This includes, but is not limited to, providing interpreter services and toll-free numbers that have adequate TTY/TTD and interpreter capability;

The individual(s) making these determinations shall have no history of disciplinary action or sanctions; including loss of staff privileges or participation restrictions, that have been taken or are pending by any hospital, governmental agency or unit, or regulatory body that raise a substantial question as to the clinical peer reviewer's physical, mental, or professional or moral character.

The individual making these determinations is required to attest that no adverse determination will be made regarding any medical procedure or service outside of the scope of such individual's expertise.

The MCO shall provide a mechanism to reduce inappropriate and duplicative use of health care services. Services shall be sufficient in an amount, duration, and scope to reasonably be expected to achieve the purpose for which the services are furnished and that are no less than

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the amount, duration or scope for the same services furnished to eligibles under the Medicaid State Plan. The MCO shall not arbitrarily deny or reduce the amount, duration or scope of required services solely because of diagnosis, type of illness or condition of the member. The MCO may place appropriate limits on a service on the basis of medical necessity or for the purposes of utilization control (with the exception of EPSDT services), provided the services furnished can reasonably be expected to achieve their purpose in accordance with 42 CFR \$438.210.

The MCO shall ensure that compensation to individuals or entities that conduct UM activities is not structured to provide incentives for the individual or entity to deny, limit, or discontinue medically necessary covered services to any member in accordance with 42 CFR §438.6(h), 42 CFR §422.208, and 42 CFR §422.210.

For standard service authorization decisions that deny or limit services, as expeditiously as the member's health condition requires and within fourteen (14) calendar days following receipt of the request for service, with a possible extension of up to fourteen (14) additional calendar days, if:

- The member, or the provider, acting on behalf of the member and with the member's written consent, requests extension; or
- The plan justifies (to LDH upon request) a need for additional information and how the extension is in the member's interest.

On the date the timeframe for service authorization as specified in § 13.6.3.3 expires. Untimely service authorizations constitute a denial and are thus adverse actions.

Additional Notes:

Stipulation: Well's Law Suit

Class member claims that are covered by this stipulation include the denial, the partial denial, or the failure to issue a response to a request for prior authorization for services including medical appliances, equipment and supplies as well as professional services, except the following Medicaid items and services:

- Services provided in a federally qualified health center (FQHC) or rural health ell's
- clinic (RHC)
- Program for All-Inclusive Care for the Elderly denials of particular services (but notices denying eligibility for PACE are covered by this Stipulation)
- Pharmacy point of sale denials
- The Department's current targeted case management offerings
- Services through Early Steps
- Non-emergency Medical Transportation

Denials or partial denials of these excluded services are not within the matter at issue in this suit and any issues concerning them are expressly reserved without prejudice.

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The terms "denial" and "partial denial" refer to situations in which services or items requested are not fully approved, including any situation in which a service or item other than the exact service or item requested is approved. Denials and partial denials are within the scope of the claims whether denied directly by Medicaid, or by a contractor with Louisiana Medicaid. Partial denials include, but are not limited to, situations where a service has been requested for a period of time and is approved for a shorter period of time, fewer hours of a service than requested are approved, or a different item or service from that requested is approved. Denials and partial denials also include but are not limited to situations where previously approved services are being terminated or reduced. Partial denials also include decisions where the Department or contractor approve the requested item or service, but sets the amount to be reimbursed lower than that requested. (But notices where only the amount of reimbursement is reduced need not comply with 11 G, below.) No separate notices as to prior approval need issue when a recipient is or has been notified in writing that their Medicaid eligibility is ending.

Any potential claim of a class member that he or she is unable to obtain prior approval of Medicaid services because a provider or assessor has refused to submit a request for approval of the services is not within the matters at issue in this suit and is expressly reserved without prejudice.

Any claim of a class member not related to denial or partial denial notices, or that arises after, or which presents a live controversy after, the termination of this agreement under § IV, is not a matter determined in this suit, and it is expressly reserved without prejudice.

The merits of any future denial of extended home health services to the named plaintiff is not a matter determined in this Stipulation, and it is expressly reserved without prejudice.

ADEQUATE NOTICES OF ADVERSE ACTION

At the time of any denial or partial denial, the Louisiana Department of Health and Hospitals shall issue written notice to a Medicaid recipient that includes the following: a. The notice shall describe the specific reasons for the denial or partial denial of the requested item or service, in plain language and in sufficient detail to inform the recipient and his or her physician of any further information needed to support the request, including information that:

(1) describes the considerations that played a role in the assessor's determination of what items or services, and how many hours or amounts of the item or service, should be authorized;

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- (1) would assist the recipient in understanding why the item or service is being denied or partially denied:
- (1) would enable the recipient to review the agency's assessment of his or her needs;
- (1) would assist the recipient in preparing a meaningful defense in the event that he or she wishes to appeal the agency's determination.

"Plain language" means language that the intended audience, including individuals with limited English proficiency, can readily understand and use because the language is concise, well-organized, and follows best practices of plain language writing.

- b. If the decision relies on a regulation it is not sufficient to say that the regulation is not satisfied, but the notice should explain the application of the regulation to the individual's case.
 - Reasons such as "the service is not shown to be medically necessary based on the documentation submitted," without giving a reason why the conclusion was reached, are insufficient.
 - . The Department's or a contractor's conferring with or obtaining a statement from the prescribing physician that he or she now agrees to services less than originally prescribed does not relieve the Department of these obligations.
 - All reasons for denial should be given at the same time. If a Medicaid recipient requests a fair hearing regarding an adverse action, the Department and its contractors shall not introduce other reasons in support of a denial, not stated on the denial or partial denial notice.
 - . The service or item requested should be identified in terms commonly used by laypersons to describe the service. The number of hours of services a week requested, approved and denied should be included.
 - . If a request is not fully approved, the term "denied" or "denial" should be prominent on the notice, but the notice may begin by informing the beneficiary of the services and amounts that have been approved. The notice shall specify the services and amounts that are denied in plain language.
 - Notices should use at least 12 point type and shall not be in all capital letters.
 - . Notices shall be written in plain language.

DEFINITIONS:

* Denotes terms for which Healthy Blue must use the State-developed definition.

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Act 330/House Bill 424: requires Medicaid managed care organizations relative to information on denied claims to be transmitted to healthcare providers; to provide for notices by Medicaid managed care organizations; to require Medicaid managed care organizations to take certain actions pursuant to denial of prior authorization requests by healthcare providers; to require publication of certain information relative to prior authorization requirements on the websites of Medicaid managed care organizations.

Action: The denial or limited authorization of a requested service, including the type or level of service; the reduction, suspension, or termination of a previously authorized service; the denial, in whole or in part, of payment for a service, the failure to provide services in a timely manner as defined by Sections 7.3 and 7.5 of this RFP; or the failure of the MCO to act within the timeframes provided in Section 13.7.1 of this RFP.

An Action includes a:

- b) Denial or limitation of authorization of a requested service, including the type or level of service
- b) Reduction, suspension, or termination of coverage of a previously authorized service
- b) Denial, in whole or in part, of payment for a service which results in the service not being provided.
- b) Failure to provide services in a timely manner, as defined by the State
- Failure of an HMO/MCO to act within appropriate timeframes for the resolution of medical necessity appeals.
- b) Member residing in a locality where a single contracted MCO operates under the Federal Rural Exception guidelines, the denial of the member's request to exercise his/her right to obtain services outside of the network

All determination of action notices must be in writing and must meet the language and format requirements of 42 CFR §438.10 (c) and (d) and Section 12 of the State contract to ensure ease of understanding must be completed within the State contractual, Balanced Budget Act (BBA) or National Committee for Quality Assurance (NCQA) timeline guidelines.

Administrative Denial: — The denial for payment of a requested service or confinement for reasons that are unrelated toother than a lack of medical necessity, such as late notification by a practitioner of an admission, or failure of a practitioner to pre-certify a service that requires precertification, or ineligibility on date of service, that does not require review by a Medical Director or appropriate practitioner.

Adverse Action – Any decision by Healthy Blue to deny a service authorization request or to authorize a service in an amount, duration or scope that is less than requested.

<u>Adverse Benefit Determination – Means any of the following:</u>

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- The denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit.
- The reduction, suspension, or termination of a previously authorized service.
- The denial, in whole or in part, of payment for a service.
- The failure to provide services in a timely manner, as defined by the State.
- The failure of Healthy Blue to act within the timeframes provided in 42 CFR §438.408(b)(1) and (2) regarding the standard resolution of grievances and appeals.
- The denial of a member's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other member financial liabilities.

Appeal Procedure – A formal process whereby an enrollee can request review or contest an adverse determination rendered by Healthy Blue, which resulted in the denial, reduction, suspension, termination or delay of health care benefits/services. The appeal procedure shall be governed by federal and state laws and regulations and all applicable court orders and consent decrees.

Appropriate Practitioner - A representative who makes utilization management medical necessity determinations. Depending on the type of case, the reviewer may be the health plan Medical Director, or a board-certified consultant, physician, pharmacist, chiropractor, doctorallevel clinical psychologist, dentist, nurse practitioner, physical therapist, or other appropriate licensed practitioner type. Licensed health care professionals may include qualified practitioners in accordance with state lawsmedical, behavioral health, pharmaceutical, dental, chiropractic or vision practitioner as appropriate.

- -The qualifications of staff who determine medical necessity are identified.
- Determinations of medical necessity must be made by qualified and trained practitioners in accordance with state and federal regulations.
- · Healthy Blue ensures that only licensed clinical professionals with appropriate clinical expertise in the treatment of a member's condition or disease determine service authorization request denials or authorize a service in an amount, duration or scope that is less than requested.
- The individual(s) making these determinations shall have no history of disciplinary action or sanctions; including loss of staff privileges or participation restrictions, that have been taken or are pending by any hospital, governmental agency or unit, or regulatory body that raise a substantial question as to the clinical peer reviewer's physical, mental, or professional or
- The individual making these determinations is required to attest that no adverse determination will be made regarding any medical procedure or service outside of the scope of such individual's expertise.
- Compensation to individuals or entities that conduct utilization management activities is not structured to provide incentives for the individual or entity to deny, limit, or discontinue

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medically necessary covered services to any member in accordance with 42 CFR §438. 3 (i) and 42 CFR §422.208.

Informal Reconsideration – Appeal process that allows the member (or provider/agent on behalf of a member) a reasonable opportunity to present evidence, and allegations of fact or law, in person as well as in writing. This can occur anytime during the review process. A peerto-peer allows the member/provider the opportunity to discuss a medical necessity denial decision with the Medical Director or appropriate practitioner.

Concurrent Review: A review for an extension of a previously approved, ongoing course of treatment over a period of time or number of treatments. Concurrent reviews are typically associated with inpatient care, residential care for behavioral health, intensive outpatient behavioral health or ongoing ambulatory care.

Diagnosis Related Group (DRG): A system developed by the U.S. government for determining how much Medicare should reimburse hospitals for medical care. DRGs are assigned by a "grouper" program based on ICD diagnoses, procedures, age, sex, discharge status, and the presence of complications or co-morbidities. DRG classification may vary by state and product.

Health Care Acquired Conditions (HCAC): Term used by Medicaid to identify medical conditions that occur during the course of a hospital admission. The reviewer will need to identify and utilize the associated HCAC code when certain conditions are identified. See the References section to access the Center for Medicare and Medicaid website link with a list of the HCAC.

Medical Denial.—An admission, continued stay, availability of care, or other healthcare service that has been reviewed by Healthy Blue and based upon the clinical information provided, does not meet the requirements for medical necessity, level of care, healthcare setting, appropriateness, or effectiveness, and the requested service is therefore denied, reduced, suspended, delayed, or terminated. The denial for payment or limited authorization of a requested service, the reduction, suspension or termination of a previously authorized service based on review of medical necessity.

Medically Necessary Services* – Those health care services that are in accordance with generally accepted, evidence-based medical standards or that are considered by most physicians (or other independent licensed practitioners) within the community of their respective professional organizations to be the standard of care. In order to be considered medically necessary, services must be: (1) deemed reasonably necessary to diagnose, correct, cure, alleviate or prevent the worsening of a condition or conditions that endanger life, cause suffering or pain or have resulted or will result in a handicap, physical deformity or malfunction; and (2) those for which no equally effective, more conservative and less costly course of treatment is available or suitable for the beneficiary. Any such services must be individualized, specific and consistent with symptoms or confirmed diagnosis of the illness or injury under

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treatment, and neither more nor less than what the beneficiary requires at that specific point in time. Although a service may be deemed medically necessary, it doesn't mean the service will be covered under the Medicaid Program. Services that are experimental, non-FDA approved, investigational, or cosmetic are specifically excluded from Medicaid coverage and will be deemed "not medically necessary."

Not Liable Denial: — An administrative denial of a request for services based on a lack of the health plan liability for the requested services (e.g., the member is no longer eligible for services through the health plan). There are certain instances where the Medical Director (or appropriate practitioner) is required to review and render a determination for not liable reasons.

Notice of Action: $\underline{}$ The $\underline{}$ Communication of a proposed action.

Provider Preventable Condition (PPC)/Health Care Acquired Condition (HCAC) — Preventable healthcare-acquired or other provider-preventable conditions and events, also known as never events, identified by the Louisiana Department of Health (LDH) for nonpayment, such as but not limited to, bed pressure ulcers or decubitus ulcers; or events such as surgical or invasive procedures performed on the wrong body part or wrong patient; wrong surgical procedure performed on a patient.

Service Authorization — A utilization management activity that includes prospective, concurrent, or post-review of a service by a qualified health professional to authorize, partially deny, or deny the payment of a service, including a service requested by the enrollee. Service authorization activities must consistently apply review criteria.

Peer to Peer: The process of giving a practitioner the opportunity to discuss a medical necessity denial decision with an appropriate health plan Medical Director (or appropriate practitioner), this can happen at any time during the review process.

Post-Service Review (Retrospective): The review process performed on all requests for certification of services that have already been rendered by a practitioner. If the request is made while the member is in the process of receiving care NCQA considers this to be an urgent concurrent request if the medical care meets the definition of urgent, even if the services were not precertified prior to care.

Pre-Service Review: The review process performed on all requests that require precertification, in whole or in part, in advance of a member obtaining services (e.g. urgent or elective inpatient admissions and outpatient services, including primary care, outpatient behavioral health and specialty care).

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Reconsideration (known as a Reopen by Medicare): The process of giving a practitioner the opportunity to discuss a medical necessity denial decision with an appropriate health plan Medical Director (or appropriate practitioner) after a denial has been issued. Availability and requirements for reconsiderations vary by health plan. Where available, reconsideration is not considered to be an appeal and does not limit subsequent appeal rights.

Urgent Care: Medical care provided for a condition that without timely treatment, could be expected to deteriorate into an emergency, or cause prolonged, temporary impairment in one or more bodily function, or cause the development of a chronic illness or need for a more complex treatment. Examples of conditions that require urgent care include abdominal pain of unknown origin, unremitting new symptoms of dizziness of unknown cause, and suspected fracture. Urgent care requires timely face-to-face medical attention within 24 hours of member notification of the existence of an urgent condition.

For urgent care decisions, the organization allows a health care practitioner with knowledge of a member's behavioral health condition (e.g., a treating practitioner) to act as the authorized representative of the member.

Government Business Division

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PROCEDURE:

Medical Necessity Review

Medical necessity review requires that denial decisions be made by an appropriate clinical professional as specified in NCQA standards. Denials resulting from medical necessity review are within NCQA scope of review.

Decisions about the following **require** medical necessity review:

- 1) Covered medical benefits defined by the organization's Certificate of Coverage or Summary
- 2) Preexisting conditions, when the member has creditable coverage and the organization has a policy to deny preexisting care or services.
- 3) Care or services whose coverage depends on specific circumstances.
- 4) Dental surgical procedures that occur within or adjacent to the oral cavity or sinuses and are covered under the member's medical benefits.
- 5) Out-of-network services that are only covered in clinically appropriate situations.
- 6) Prior authorizations for pharmaceuticals and pharmaceutical requests requiring prerequisite drug for a step therapy program.
- 7) "Experimental" or "investigational" requests, unless the requested services or procedures are specifically excluded from the benefits plan and deemed never medically necessary under any circumstance in the organization's policies, medical necessity review is not required.

Decisions about the following do not require medical necessity review:

- 1) Services in the member's benefits plan that are limited by number, duration or frequency.
- 2) Extension of treatments beyond the specific limitations and restrictions imposed by the member's benefits plan.
- 3) Care that does not depend on any circumstances.

Requests for coverage of out-of-network services that are only covered when medically necessary or in clinically appropriate situations require medical necessity review. Such requests indicate the member has a specific clinical need that the requestor believes cannot be met innetwork (e.g., a service or procedure not provided in-network; delivery of services closer or sooner than provided or allowed by the organization's access or availability standards).

If the certificate of coverage or summary of benefits specifies that the organization never covers an out-of-network service for any reason or if the request does not indicate the member has a specific clinical need for which out-of-network coverage may be warranted, the request does not require medical necessity review.

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Requests for personal care services, such as cooking, grooming, transportation, cleaning and assistance with other activities of daily living (ADL).

Medical Denial

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Medical Denial Reasons and Medica	Management Claims Payment System
Coo	des
Not Medically Necessary	DD01
Inappropriate Level of Care	DD04
Lower Level of Care (Nevada)	DD17
Delay In Care/Services	DD05
Lack of Information	DD03
Care Available in Network	DD19

1)

a)1) Any medical necessity decision (medical or behavioral health) to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested, must be made by a health carelicensed physician (or appropriate practitioner) as professional who has appropriate to the scope of their expertise and training, consistent with the Contract and state and federal regulations clinical expertise in treating the member's condition or disease. Such health care professionals include the health plan Medical Director, a board certified consultant, or a medical, behavioral health, pharmaceutical, dental, chiropractic and vision practitioner under the clinical direction of the health plan Medical Director.

a) It is the provider's responsibility to submit all clinical information necessary to justify both severity of illness and intensity of service. If the clinical submitted is inadequate, Healthy Blue may deny the request or request additional information.

- b) Documented Eefforts are made to obtain the necessary information to provide additional support for decisions based on established medical necessity criteria. When Healthy Blue requests additional information, the turnaround time clock for concurrent review does not start until all necessary clinical information to make the decision to approve or deny initial or continued inpatient stay is received. Specific requirements mandated by State will be followed.
- c) When submitting additional documentation, providers should only submit the pertinent clinical information needed to justify severity of illness and intensity of service.
- i)d) In cases where the provider or member will not release necessary information, Healthy Blue may deny authorization of requested services within two (2) business days.
- ii)e) In the event there is insufficient information to render an approval, the request case is managed as a medical necessity decision and therefore forwarded to the health plan Medical Director (or appropriate practitioner) for final medical necessity determination.

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- 2) The health plan Medical Director (or appropriate practitioner) is available to make decisions as needed and in urgent cases and on an as needed basis for all other cases, as required by the medical situation. The failure to complete the precertification request in a timely manner constitutes a denial and is considered an action by the health plan.
 - a) The determination and rationale of the Medical Director (or appropriate practitioner) is documented, the appropriate denial code (as noted in the grid above) is entered in the medical management system, and the notice of proposed action is generated.

b)

c) Based on the health plan Medical Director (or appropriate practitioner) determination, the designated health plan Health Care Management (HCM) or Behavioral Health (BH) staff generates the notice of proposed action, enters the appropriate denial code (as noted in the grid above) in the applicable claims payment system and documents the attempts to obtain the clinical information.

NOTE: In the event there is a pre-service request entered into the claims payment system that has been is identified as appropriate for a lower level of care (i.e., elective inpatient admission appropriate for outpatient) and the member has not <u>vet</u> received the service, the health plan clinician discusses the most appropriate level of care with the provider/facility clinician the most appropriate level of care. If the provider/facility is in agreement with the decision, the designated HCM or BH staff updates the applicable claims system and documents all the applicable information is documented and the medical management system is updated to reflect the appropriate, agreed upon lower level of care. This does not constitute a denial, and a noticed of proposed action is not required.

Administrative Denial

2)

Administrative Denial Reasons and & Claims Payment Medical Management		
System Codes		
Late Notification of Admission	DD02	
Failure to Precertify	DD10	

a)1) Late Notification of an Admission (not applicable to Emergency Services); Notification of admission is the essential first step for the provider in the authorization process. It is important to remember that the notification step is separate from the submission of clinical for review. Providers should only submit notification and clinical information to the number(s) specified by Healthy Blue. Provideractitioners are required to notify the National Customer Care department (NCC) or Clinical Behavioral Health, (BH) staff within twenty-four (24) hours, or one (1)the next business day, of an inpatient admission for admission review.

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- a) Late notification is issued when Healthy Blue is notified of an emergent inpatient admission greater than one (1) business day after the admission or actual date of service:
 - i) Emergency room (ER)/direct admit to a general floor (i.e., medical surgical bed);
 - ii) Neonatal intensive care unit (NICU) level I and II;
 - <u>iii)</u> Inpatient transfers between acute, rehabilitative, long-term acute care (LTAC), or skilled nursing facilities (SNF);
 - iv) Inpatient transfer to a general bed from an intensive care unit (ICU)/telemetry/NICU III or post-surgery;
 - v) Notification greater than ten (10) days after a member admitted regardless of status;
 - vi) Notification occurred after a member discharged home; and
 - vii) Outpatient procedures listed as "notification."
- b) If the member is still inpatient when the health plan a late is notification is receiveded, the health plan HCM, BH staff or health plan Medical Director (or appropriate practitioner) administratively denies the days prior to notification are administratively denied and applies medical necessity criteria is applied for the remaining days.
- c) If Healthy Blue the health plan was is not notified of the admission and the member has been discharged, the health plan HCM associate or health plan Medical Director (or appropriate practitioner) administratively denies the entire stay is administratively denied for non-notification.
 - NOTE: In some cases, notification and/or initial clinical is sent on the day of discharge or after discharge. These cases do not fall into the concurrent review category, but fall into the retrospective or post-service authorization category as the service has already been provided and Healthy Blue has no ability to impact the stay.
- d) The late notification denial reason (DD02) is also utilized for late clinical submissions.
 - i) Healthy Blue is held accountable by LDH to meet turnaround time deadlines, and therefore has the authority to implement and require adequate processing time for submitted clinical information by providers. Providers submitting clinical information for concurrent review or as otherwise directed, have a submission deadline of 3:00 pm Central Standard Time (CST), with a ten (10) minute grace period.
 - ii) It is the provider's responsibility to submit clinical information for review by the specified "Next Review" date and deadline of 3:10 pm CST.
 - iii) If the "Next Review" date notification sent by Healthy Blue to the provider is a past date, retrospective, or the same day of receipt, the provider has until 3:10 pm CST on the next business day to submit clinical information.
 - iv) Receipt of administrative denial is based on timely notification, not medical necessity. Upon receipt of this denial, providers have until 3:10 pm CST the next business day to submit clinical information for the days following the denied day to be considered for medical necessity and minimize additional denied days.

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i)e) Proof of a fax confirmation for transmittal prior to the specified time will be accepted as meeting the deadline. If documentation was not submitted within the required timeframe, the admission or length of stay extension will be denied.

- f) Prior to the issuance of a <u>n administrative</u> at notification denial, the BH staff obtains approval is obtained from the <u>Utilization Management</u> BH—manager or <u>his/her</u> designee above.
- g) The determination rationale and appropriate denial code (as noted in the grid above) are entered in the medical management system and the notice of proposed action is generated.

 (0)
- 2) Failure to Precertify: Precertification requests are required to be submitted a minimum of seventy-two (72) hours before services are rendered. Requests made less than this timeframe may result in an administrative denial;
 - a) Failure to precertify is issued for preservice requests less than seventy-two (72) hours in advance of the requested service:
 - i) Elective admission to an acute inpatient facility;
 - ii) Admission to inpatient hospice; or
 - iii) Admission to a SNF, LTAC, or a rehabilitative facility.
 - b) If notification was received after an elective inpatient admission but the member is still inpatient, the days prior to the notification are administratively denied and medical necessity criteria is applied for the remaining days.
 - c) During the course of review, the reviewer should determine if an inpatient stay was the result of a complication of an outpatient procedure; if uncertain due to inability to obtain necessary information, the request is referred to the Medical Director or appropriate practitioner.
 - d) The determination rationale and appropriate denial code (as noted in the grid above) are entered in the medical management system and the notice of proposed action is generated.
-) If the health plan is not notified of the admission and the member has been discharged, the health plan HCM associate or health plan Medical Director (or appropriate practitioner) administratively denies the entire stay for non-notification.
- The designated health plan HCM or BH staff generates the notice of proposed action, enters the appropriate denial code (as noted in the grid above) in the claims payment system and documents all applicable information.

Note: Reference Coverage for Post-Stabilization Care Services and Emergency Services Procedures for notification standards and timeframes.

Not Liable Denial

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Not Liable Denial Reasons and Claims Payment Medical Management		
System Codes		
Ineligible on Date of Service	DD06	
Non-Covered Service/Benefit	DD07	
Benefit Exhausted	DD08	
Other Health Insurance	DD11	

For the following Not Liable Denials, the designated health plan HCM, NCC or BH staff · enters the appropriate denial code (as noted in the grid above) in the claims payment system and documents all applicable information

b) Ineligible on Date of Service: The designated health plan HCM, NCC or BH staff advises the requesting provider is advised actitioner that the member is not eligible with Healthy Bluethe health plan, continued and no action is taken when applicable.

1)

2) There are instances when the health plan Medical Director (or appropriate practitioner) must reviews and renders a determination for nNot Liable rReasons:

-Non-Covered Service/Benefit:

- (0)-The designated health plan HCM or BH staff notifies the requesting practitioner of the health plan Medical Director (or appropriate practitioner) decision to deny the non-covered service/benefit and generates the denial notification letter.
 - iv) NOTE: If the requested service is non-covered under any circumstance, NCQA does not require a Medical Director (or appropriate practitioner) review of requests for medical services specifically excluded from the health plan's benefit plan.
 - i) **BNOTE**: If the requested service is non-covered under any circumstance, NCQA does not require a Medical Director (or appropriate practitioner) review of requests for medical services specifically excluded from the health plan's benefit plan.
 - b) Benefit Exhausted; and
 - c) Other Health Insurance (OHI).
 - If a member has OHI, existing authorization rules remain applicable. If authorization is required when Healthy Blue is the member's primary insurance, an authorization is required when Healthy Blue is secondary.
 - ii) Do not try to redirect non-participating requests to a participating provider.
 - iii) If OHI is reported by a member or provider that is not listed under coordination of benefits (COB) in the medical management system, or there is a discrepancy in the information, the associate:

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- (1) Obtains as much information as offered during request review;
- (2) Notifies the Cost Containment Unit via email at ccuohi@amerigroupcorp.com; and
- (3) Proceeds with processing the request regardless of the member's OHI as long as the member remains eligible; the request is not denied due to OHI in these instances.
- d) In these instances, the decision and rationale of the Medical Director (or appropriate practitioner) is documented in the medical management system, the appropriate denial code (as noted in the grid above) is entered, and the notice of proposed action is generated.

(0) The designated health plan HCM or BH staff notifies the requesting practitioner of the health* plan Medical Director (or appropriate practitioner) decision to deny extension of treatment and generates both the exhaustion of benefit notification letter and notice of proposed action.

Health Care Acquired Condition (HCAC)/s-Provider Preventable Condition (PPC) Denial

4)

Health-Care Acquired Conditions Denial Reasons and & Claims Payment		
Medical Management System Codes		
HCAC Condition	DS14	
(Disallowed)	D314	
HCAC Condition	-DD29	
(Discharged)		
HCAC Condition	DD20	
(Partial Denial)	LD14 (Services)	

- a)1) All applicable information is documented, The health plan staff enters the appropriated denial code (as noted in the grid above) is entered in the medical management claims payment system, and the notice of proposed action is generated. Denial reasons include and documents all applicable information for the following:
 - i)a) Inpatient admission resulting from a HCAC during an Emergency Room visit or Observation stay (DS14);-
 - ii)b) HCAC denial that occurred during the admission and the member has discharged (DD29); and
 - <u>c)</u> Partial hospital days during an inpatient <u>stay</u> are denied <u>(DD20)</u>.
- 2) Healthy Blue shall deny payments to providers for PPC as defined by LDH in the <u>Medicaid</u> Medicaid Services Manual. PCC are defined in two (2) separate categories:
 - a) HCAC as defined by the Centers for Medicare and Medicaid Services (CMS); and

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 i) Louisiana Medicaid considers HACs as identified by Medicare, other than deep vein thrombosis (DVT)/pulmonary embolism (PE) following total knee replacement or hip replacement surgery in pediatric and obstetric patients.

b) Other provider preventable conditions (OPPC), such as surgery on a wrong body part, wrong surgery on a patient, or surgery on a wrong patient.

3) Healthy Blue requires all providers to report PPCs associated with claims for payment or member treatment for which payment would otherwise be made. The health plan reports all identified PCC to LDH in the format specified by LDH.

<u>Documentation of Medical Director Medical Necessity Review Decisions (Approvals or Denials):</u>

- 1) The health plan Medical Director (or appropriate practitioner), NCC, health plan HCM or BH*

 staff documents aAll Medical Director decisions are documented and appropriately reflected as a Physician Advisor (PA) note in the claims payment medical management system. DThe documentation must contain the following:
 - a) Criterion or guideline utilized to render the decision;
 - b) Reference of the clinical information submitted by the provideractitioner;
 - Informal reconsideration or <u>Ppeer-to-peer review results</u>, if applicable (based on State contracts); and
 - d) Decision rationale; and

-

- The name of the health plan—Medical Director (or appropriate practitioner) who rendered the decision must be referenced in the notes; and their user identification number must be populated in the Secondary Reviewer field by the Medical Director or designated staff documenting on their behalf.
- e) The claims payment system must reflect all necessary information in the appropriate screens and fields.
- 2) Although medical necessity criteria are reviewed with each level of care request, these items are only guidelines and just one factor that is considered in medical necessity reviews.

 Because each level of care review represents a unique clinical scenario that may not be fully described by the guidelines, other considerations, including but not limited to things such as practice patterns and professional experience and judgement, may also be factored into each final medical necessity determination.

Informal Reconsideration

The informal reconsideration or peer-to-peer process allows the member (or provider/agent on behalf of a member) a reasonable opportunity to address a medical necessity denial decision by presenting evidence, and allegations of fact or law, in person as well as in writing. This can occur anytime during the review process. Informal reconsiderations should occur within one (1) working day of the receipt of request and be conducted between the provider rendering the

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service and the Healthy Blue Medical Director who made the adverse determination (or designated clinical peer). The informal reconsideration will in no way extend the thirty (30) day required timeframe for a Notice of Appeal Resolution. Refer to *Informal Reconsideration – LA* for the detailed policy and procedures.

NOTE: The member is allowed sixty (60) calendar days from the date on Healthy Blue's notice of action or inaction to request a formal appeal. If a member or provider requests a procedure or service that was previously denied within the last sixty (60) calendar days, refer the member/provider to their appeals rights; do not enter a new request. If a member or provider requests a procedure or service that was previously denied greater than sixty (60) calendar days, enter a new request.

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1) Peer to Peer (P2P) Reconsideration:

The process of giving a practitioner the opportunity to discuss a medical necessity denial* decision with an appropriate health plan Medical Director (or appropriate practitioner), this can occur once a denial has been issued must be within the allowed timeframe listed below.

The requesting practitioner contacts the health plan HCM or BH staff to request a reconsideration discussion.

The designated health plan HCM or BH staff reviews the request and determines if the reconsideration is appropriate (i.e. the request for the P2P is within five (5) business days from the issuance of the notice of denial via the health plan fax.).

-) If the request is outside of the appropriate timeframe the practitioner is instructed to follow the appeals process as indicated within the notice of proposed action letter and documents in the claims payment system.
-) If the request is within the appropriate timeframe, the request is forwarded to the appropriate health plan designee to schedule the P2P discussion. The health plan will schedule the discussion within one (1) business day of the receipt of the request.
- All P2P discussions must be completed within ten (10) total business days from the first issuance of the fax denial notification. This includes the scheduling and completion of the P2P.
- If the provider is unable to accept or schedule a discussion within this timeframe the request for a P2P will be closed and the next course of action for the provider will be the appeal process.
- . P2P discussions are conducted by the member's physician and the health plan Medical Director making the initial determination (or appropriate physician under the direction of the health plan Medical Director if the original health plan Medical Director is not available). The health plan Medical Director completes the P2P discussion with the requesting physician.
- -) If the health plan Medical Director (or appropriate practitioner) informs the practitioner that he/she is upholding the original denial decision, the health plan Medical Director (or appropriate practitioner) also notifies the practitioner of applicable appeal rights, documents

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the decision in the claims payment system and routes the case back to the designated health plan HCM or BH staff to complete the reconsideration notice of proposed action denial letter if the initial notice of proposed action letter was issued.

-) If the health plan Medical Director (or appropriate practitioner) informs the practitioner that he/she is reversing the original denial decision, the health plan Medical Director (or appropriate practitioner) documents the decision in the claims payment system and routes the case back to the designated health plan HCM or BH staff. If the initial notice of proposed action letter was issued the health plan HCM or BH staff will update the claims payment system with the appropriate "appeal overturn" code and complete the reconsideration notice of proposed action approval letter.
- xvii. If possible the Medical Director documents (in the original denial letter and in Facets) the specific information to be received from the practitioner that would result in an approval. If and when that specific information is received during the reconsideration period, the HCM clinician/pharmacist may overturn the original denial.
- xviii.-The claims payment system screens must reflect the updated approval.
- xix. The designated health plan HCM or BH staff mails or electronically sends the letter to the appropriate parties, per health plan requirements, once the health plan Medical Director (or appropriate practitioner) renders a determination.
- a) Documentation of Medical Director Medical Necessity Review Decisions (Approvals or Denials);
- <u>V)A)</u>
 The health plan Medical Director (or appropriate practitioner), NCC, health plan HCM or
 BH staff documents all Medical Director decisions as a Physician Advisor (PA) note in the claims
 payment system. The documentation must contain the following:
- +i)-Criterion or guideline utilized to render decision;
- +i)-Reference of the clinical information submitted by practitioner;
- +i)-Peer-to-peer review results if applicable (based on State contracts); and
-)i) Decision rationale.
- AA)A) The name of the health plan Medical Director (or appropriate practitioner) who rendered the decision must be referenced in the notes and their user identification number populated in the Secondary Reviewer field by the Medical Director or designated staff documenting on their behalf.
- <u>BB)A)</u> The claims payment system must reflect all necessary information in the appropriate screens and fields.

Decision Standard Timeframes:

Each type of review request has a specific timeframe for completion of the review process. All timeframes begin with the request for review, and end with the issuance of the notification of determination. Healthy Blue complies with NCQA, Accreditation Association of Ambulatory Health Care (AAAHC), state and federal standards.

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<u>NOTE: NCQA does not require an initial oral notification of a determination for Urgent Pre-</u> <u>Service and Urgent Concurrent Reviews. Unless Federal Medicare (CMS) or the State mandates</u> <u>otherwise, standard timeframes are listed below:</u>

State contractual timing of service authorization decisions and notice of action are as follows:

- 1) EThe MCO shall make eighty percent (80%) of standard service authorizations determinations shall be made within two (2) business days of obtaining appropriate medical information that may be required regarding a proposed admission, procedure, or service requiring a review determination, with the exception of authorizations for Community Psychiatric Support and Treatment (CPST) and Psychosocial Rehabilitation (PSR) services for which the standard for determination is within five (5) calendar days of obtaining appropriate medical information_All s§tandard service authorization determinations shall be made no later than fourteen (14) calendar days following receipt of the request for service.
 - a) The service authorization decision may be extended up to fourteen (14) additional calendar days if:
 - i) The member, or the provider, requests the extension; or
 - ii) Healthy Blue justifies (to LDH upon request) a need for additional information and how the extension is in the member's interest.
- 2) NThe MCO shall make ninety-five percent (95%) of concurrent review determinations shalled be made within one (1) business day and ninety-nine point five percent (99.5%) of concurrent review determinations within two (2) business days of obtaining the appropriate medical information that may be required.
- 3) In the event a provider indicates, or Healthy Bluethe MCO determines, that following the standard service authorization timeframe could seriously jeopardize the member's life or health or ability to attain, maintain, or regain maximum function, Healthy Bluethe MCO shall make an expedited authorization decision and provide notice as expeditiously as the member's health condition requires, but no later than seventy-two (72) hours after receipt of the request for service.
 - a) Healthy Blue The MCO may extend the seventy-two (72) hour time period by up to fourteen (14) calendar days if the member or if Healthy Blue the MCO justifies to LDH a need for additional information and how the extension is in the member's best interest.
- 4) Post Authorization The MCOR shall make retrospective review determinations shall be made within thirty (30) days of obtaining the results of any appropriate medical information that may be required, but in no instance later than one hundred eighty (180) days from the date of service.
- 5) Healthy Blue The MCO shall not subsequently retract its authorization after services have been provided or reduce payment for an item or service furnished in reliance upon previous service authorization approval, unless the approval was based upon a material omission or misrepresentation about the member's health condition made by the provider.
- 6) For service authorization approval for a non-emergency admission, procedure or service, the provider shall be notified verbally or as expeditiously as the member's health condition

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requires but not more than one (1) business day of making the initial determination and provided documented confirmation of such notification to the provider within two (2) business days of making the initial certification.

- 7) For service authorization approval for extended stay or additional services, the provider rendering the service, whether a health care professional or facility or both, and the member receiving the service, shall be notified verbally or as expeditiously as the member's health condition requires but not more than one (1) business day of making the initial determination and provided documented confirmation of such notification to the provider within two (2) business days of making the initial certification.
- 8) The member shall be notified, in writing using language that is easily understood by the member, of decisions to deny a service authorization request, to authorize a service in an amount, duration, or scope that is less than requested, and/or any other action as contractually defined. The notice of action to members shall be consistent with requirements in 42 CFR §438.404 and 42 CFR §438.210, contractual requirements for member written materials, and any agreements that LDH may have entered into relative to the contents of member notices of denial or partial denial of services, regardless of whether such agreements are related to legal proceedings or out-of-court settlements.
- 9) The requesting provider shall be notified of a decision to deny an authorization or reauthorization request or to authorize or reauthorize a service in an amount, duration, or scope that is less than requested. The provider rendering the service, whether a health care professional or facility or both, is notified verbally or as expeditiously as the member's health condition requires but not more than one (1) business day of making the initial determination and shall provide documented confirmation of such written notification to the provider within two (2) business days of making the initial certification.
- 10) Failure to complete a request in a timely manner constitutes a denial and is considered an adverse action by Healthy Blue.

The following are NCQA decision and notification timeframe standards:

- 1) For urgent (expedited) preservice review, a decision and notification are required within seventy-two (72) hours (or three (3) calendar days) of receipt of the request.
- 2) For urgent concurrent review for pharmacy requests, a decision and notification are required within twenty-four (24) hours (or one (1) calendar day) of receipt of the request.
- 3) For behavioral health and non-behavioral health (physical health) urgent concurrent reviews, a decision and notification are required as expeditiously as the member's health condition requires, but no later than within seventy-two (72) hours (or three (3) calendar days) of receipt of the request.
- 4) For non-urgent preservice review, a decision and notification is required within fourteen (14) calendar days from the receipt of the request.
- 5) For post-service review, a decision and notification is required within thirty (30) calendar days of receipt of the request.

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- 6) For a reconsideration Review, a decision and notification is required within twenty-four (24) hours (or one (1) business day) of receipt of the urgent preservice or urgent concurrent request. A decision and notification is required within seven (7) business days of receipt of the non-urgent preservice or post-service request.
- 7) A possible extension of the above timeframes may occur if:
 - a) The member or practitioner, acting as the member's authorized representative, voluntarily agrees to extend the decision-making timeframe; or
 - b) The health plan justifies the need for additional information and how the extension is in the member's best interest to the appropriate state agency if required.
- 8) The initial oral or fax notification must reflect the time and date notification occurred, and who provided the notification.
- 9) The written notification must be issued no later than three (3) calendar days after the initial oral or fax notification, and reflect the date the notification was created.

NOTE: NCQA does not require an initial oral notification of a determination for urgent preservice and urgent concurrent reviews. Healthy Blue records the date, time, and associate who spoke with the provider and/or member for all notifications.

- A voicemail is not an acceptable form of oral notification.
- A fax may be sent as the initial notification. For urgent concurrent denials, the fax should include a statement asking the hospital Utilization Review (UR) department staff to notify the attending/treating practitioner of the decision.
- Electronic or written notification must be provided no later than three (3) calendar days after the initial notification.

Notice of Adverse Benefit Determination

CC) Action:

1) The health plan provides written notification of adverse decisions to the member and requesting practitioner and member. For urgent care requests, practitioners are assumed to be acting as the member's representative.

CC)

CC).The health plan must mail the Notice of Action within the following time frames:

i) For termination, suspension, or reduction of previously authorized covered services, at least ten (10) days before the date of action. This time frame may be shortened to five (5) days if probable member fraud has been verified or by the date of action for the following:

(1) In the death of a recipient;

(2) In the receipt of a signed written recipient statement requesting service termination or giving information requiring termination or reduction of services (where he understands that this must be the result of supplying that information);

(3) The recipient's admission to an institution where he is eligible for further services;

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(4) The recipient's address is unknown and mail directed to him has no forwarding address:

(5) The recipient has been accepted for Medicaid services by another local jurisdiction; or

(6) The recipient's physician prescribes the change in level of medical care; or

(7) As otherwise permitted under 42 CFR §431.213.

CC) The health plan makes all written materials available in alternative formats and in a manner that takes into consideration the member's special needs, including those who are visually impaired or have limited reading proficiency. The health plan notifies all members (via the member handbook) that information is available in alternative formats and how to access those formats.

xii) The All-written Notice of Action must explain and notifications of an action include the following:

2)

xiii) Statement of action Healthy Blue or its contractor has being taken or intends to take by the health plan;

a)

- b) Explanation or reasons for ofthe action or denial reason in easily understood language that is specific to the member and meets state-required reading levels;
- c) Availability of interpretation services for all languages, free of charge, and how to access them;
- (0) including sSpecific reference to utilization criteria guidelines, protocols or benefits provisions used in the determination;

<u>d)</u>

information to reference a specific guideline or criterion (for a given condition, service request), the notification must state the inability to reference the most appropriate specific criteria, and must describe the information needed to render a decision in a manner specific enough for the member or member's authorized representative to understand what is needed.

i) ___

e) Notification that the <u>The</u> member's <u>right tocan</u> obtain, {upon request <u>and free of charge,}</u> copies a <u>copy</u> of all documents, records, and other information relevant to the <u>adverse benefit determination.</u> Such information includes the actual benefit provision, <u>medical necessity criteria</u>, guidelines, protocol or other similar criterion on which the denial was based, and any processes, strategies, or evidentiary standards used in setting coverage limits, upon request;

XV)

Medical management criteria and practice guidelines are posted to Healthy Blue's website. Practice guidelines are disseminated to all affected providers and, upon request, to members and potential members.

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ii) The criteria for medical necessity determinations for mental health and substance use disorder benefits are available online and, upon request, in hard copy at no cost to any enrollee, potential enrollee, or provider per 42 CFR 438.915 and 438.236.

xvi) Notification to the practitioners about the availability of and how to contact a healther plan Medical Director (or appropriate practitioner) to discuss any Utilization Management (UM) denial decisions and/or request criterion; and-

f)

The member's or practitioner's right to file an appeal and the accompanying procedures and timeframes for the member or practitioner acting on the member's behalf to request a routine or expedited or routine appeal, along with the time-frames to file an appeal, and the time frames for the health plan to decide on the appeal.

g)

D)—The member, member's representative or practitioner acting on the member's behalf, has up to sixty (60) calendar days to file an appeal upon issuance of the notice of action letter. Once the time-frame has expired, any requests for services related to the case previously denied are processed as a new precertification.

i)

- a. Practitioner's (different from the practitioner who initiated the appeal) request for services related to the case previously denied is processed as a new precertification.
- 2) The designated NCC, health plan HCM or BH staff creates a new precertification in the claims payment system and completes the appropriate screens/fields.
 - 3) The circumstances under which an expedited resolution is available (for urgent preservice or urgent concurrent denials), and how to request it;

ii)

4)—The member's right to submit written comments, documents, or other information relevant to the appeal;

iii)

5)—The member's right to the appointment of a new, nonsubordinate person to review the appeal;

iv)

The member's rights to have benefits continue pending the resolution of the appeal, how to request that benefits be continued, and the circumstances under which the member may be required to pay the costs of these services;

v)

- vi) The member's right to represent himself/herself or designate legal counsel, a relative, a friend, or other spokesperson_j.
- 7) The member's right to request an evidentiary hearing if one is available or a State agency hearing as applicable; or in cases of action based on change in law, the circumstances under which a hearing will be granted; and

VII)

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<u>viii) Notification of tThe member's right to request a state</u> fair hearing or external review organization review (based on the State's contractual requirements) after the member has exhausted the health plan -appeal procedures have been exhausted.

- 3) All written materials are available in alternative formats and in a manner that takes intoconsideration member's special needs, including those who are visually impaired or have limited reading proficiency. The health plan notifies all members, via the member handbook, that information is available in alternative formats and how to access those formats.
- 4) All written materials, regardless of the means of distribution, must comply with guidance outlined in 42 CFR §438.10 and 42 USC §1396u-(2)(d)(2)(A)(i), including:
 - a) All member materials must be in a style and reading level that will accommodate the reading skills of MCO Enrollees. In general the writing should be at no higher than a 6.9 grade level, as determined by any one of the indices below, taking into consideration the need to incorporate and explain certain technical or unfamiliar terms to assure accuracy:
 - i) Flesch Kincaid;
 - ii) Fry Readability Index;
 - iii) PROSE The Readability Analyst (software developed by Educational Activities, Inc.);
 - iv) Gunning FOG Index;
 - v) McLaughlin SMOG Index; or
 - vi) Other computer generated readability indices accepted by LDH.
 - b) All written materials must be clearly legible with a minimum font size of ten-point, preferably twelve-point, with exceptions otherwise approved by LDH.
 - c) All written materials must be in accordance with the <u>LDH "Person First" Policy, Appendix</u> NNC.
 - d) All multi-page written member materials must notify the member that real-time oral interpretation is available for any language at no expense to them, and how to access those services.
 - e) Alternative forms of communication must be provided upon request for persons with visual, hearing, speech, physical or developmental disabilities. These alternatives must be provided at no expense to the member.
 - f) The date of issue, the date or revision, and/or if the prior versions are obsolete shall be included in all member materials.
 - g) Except as indicated, Healthy Blue may develop their own materials that adhere to requirements or use State-developed model member notices. State-developed model notices must be used for denial notices and lock-in notices.

0) _

5) Denial Letters are will be sent out daily (with the exception of Sundays and federal holidays) by the DCC (Document Control Distribution Center (DCC). Notices of Action are mailed within the following timeframes:

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- b) For termination, suspension, or reduction of previously authorized covered services, at least ten (10) days before the date of action. In cases of verified member fraud, or when LDH has facts indicating that action should be taken because of probable member fraud, this timeframe is shortened to at least five (5) days before the date of action;
- c) By the date of action for the following:
 - i) In the death of a recipient;
 - ii) In receipt of a signed written member statement requesting service termination or giving information requiring termination or reduction of services (where he/she understands that this must be the result of supplying that information);
 - <u>iii) The recipient's admission to an institution where he/she is eligible for further services;</u>
 - iv) The recipient's address is unknown and mail directed to him/her has no forwarding address:
 - v) The recipient has been accepted for Medicaid services by another local jurisdiction;
 - vi) The recipient's physician prescribes the change in level of medical care; or vii) As otherwise permitted under 42 CFR §431.213.
- d) For denial of payment, at the time of any action affecting the claim according to the terms and conditions outlined in the contract between the provider and Healthy Blue.
- e) For standard service authorization decisions that deny or limit services, as expeditiously as the member's health condition requires and within fourteen (14) calendar days following receipt of the request for service, with a possible extension of up to fourteen (14) additional calendar days, if:
 - i) The member, or the provider, acting on behalf of the member and with the member's written consent, requests extension; or
 - ii) Healthy Blue justifies (to LDH upon request) a need for additional information and how the extension is in the member's interest.
- f) If Healthy Blue extends the timeframe in accordance with the specifications above, it⁴ must:
 - i) Make reasonable efforts to give the member prompt oral notice of the delay;
 - Within two (2) days, give the member written notice of the reason for the decision to extend the timeframe and inform the member of the right to file a grievance if he or she disagrees with that decision; and
 - iii) Issue and carry out its determination as expeditiously as the member's health condition requires and no later than the date the extension expires.
- g) On the date the timeframe for service authorization expires. Untimely service authorizations constitute a denial and are thus adverse actions.
- h) For expedited service authorization decisions where a provider indicates, or Healthy Blue determines, that following the standard timeframe could seriously jeopardize the member's life or health or ability to attain, maintain, or regain maximum function, Healthy Blue must make an expedited authorization decision and provide notice as

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expeditiously as the member's health condition requires and no later than seventy-two (72) hours after receipt of the request for service.

i) Healthy Blue may extend the seventy-two (72) hours' time period by up to fourteen (14) calendar days if the member requests an extension, or Healthy Blue justifies (to LDH upon request) a need for additional information and how the extension is in the member's interest.

EE)6) Healthy Blue shall not create barriers to timely due process. LDH conducts randomereviews to ensure that members receive notices in a timely manner.

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b) Standard Timeframes:

- A) Each type of review request has a specific timeframe for completion of the review process. All timeframes begin with the request for review, and end with the issuance of the notification of determination. Note: NCQA does not require an initial oral notification of a determination for Urgent Pre-Service and Urgent Concurrent Reviews. Unless Federal Medicare (CMS) or the State mandates otherwise, standard timeframes are listed below:
 - i) The MCO shall make eighty percent (80%) of standard service authorization determinations within two (2) business days of obtaining appropriate medical information that may be required regarding a proposed admission, procedure, or service requiring a review determination. Standard service authorization determinations shall be made no later than fourteen (14) calendar days following receipt of the request for service.
 - ii)i) The MCO shall make ninety-five percent (95%) of concurrent review determinations within one (1) business day and ninety-nine point five percent (99.5%) of concurrent review determinations within two (2) business days of obtaining the appropriate medical information that may be required.
 - iii)i) In the event a provider indicates, or the MCO determines, that following the standard service authorization timeframe could seriously jeopardize the member's life or health or ability to attain, maintain, or regain maximum function, the MCO shall make an expedited authorization decision and provide notice as expeditiously as the member's health condition requires, but no later than seventy two (72) hours after receipt of the request for service. The MCO may extend the seventy two (72) hour time period by up to fourteen (14) calendar days if the member or if the MCO justifies to LDH a need for additional information and how the extension is in the member's best interest.
 - iv)i)—Post Authorization—The MCO shall make retrospective review determinations within thirty (30) days of obtaining the results of any appropriate medical information that may be required, but in no instance later than one hundred eighty (180) days from the date of service.

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v)ii) The MCO shall not subsequently retract its authorization after services have been provided or reduce payment for an item or service furnished in reliance upon previous service authorization approval, unless the approval was based upon a material omission or misrepresentation about the member's health condition made by the provider.

Wells v. Gee

The Wells v. Gee Settlement provided guidance for all LDH contractors that produce denial and partial denial notices. The stipulations in Wells became active October 23, 2014. LDH staff monitored compliance and provided regular review of a sampling of denial and partial denial notices, as outlined by the settlement. The Wells Settlement terminated October 24, 2019. Louisiana Medicaid continues a level of monitoring of denial and partial denial notices in the spirit of Wells but modified to focus on adherence to the requirements provided in the Code of Federal Regulations, specifically 42 CFR 438.404.

Act 330 (House Bill 424)

House Bill 424, relative to claim and PA denials, requires Louisiana Medicaid Managed Care Organizations (MCOs) to furnish PA requirements to providers within twenty-four (24) hours of a request, or make requirements available online through the insurer's website. MCOs are required to give written notice of PA denials within three (3) days of a denial determination. If a PA or claim denial is based upon an opinion or interpretation of law, regulation, policy, procedure, or medical criteria or guideline, MCOs must provide in the written notice either instructions to access the source in the public domain or provide a copy of the source. Act 330 went into effect August 1, 2019.

EXCEPTIONS:

Healthy Blue shall provide a mechanism to reduce inappropriate and duplicative use of health care services. Services shall be sufficient in amount, duration, and scope that is no less than the amount, duration, and scope for the same services furnished to eligibles under fee-for-service Medicaid, as specified in 42 CFR §438.210(a). Upward variances of amount, duration and scope of these services are allowed.

Healthy Blue shall provide core benefits and services, and cover medically necessary services that address:

- The prevention, diagnosis and treatment of a member's disease, condition, and/or disorder that results in health impairments and/or disability;
- The ability for a member to achieve age-appropriate growth and development; and
- The ability for member to attain, maintain, or regain functional capacity.

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Healthy Blue shall ensure that services are sufficient in amount, duration, and scope to reasonably be expected to achieve the purpose for which the services are furnished. Healthy Blue shall not arbitrarily deny or reduce the amount, duration, or scope of a required service because of diagnosis, type of illness, or condition of the member.

Healthy Blue may place appropriate limits on a service:

- 1) On the basis of certain criteria, such as medical necessity or best practices;
- 2) For the purpose of utilization control, provided the services furnished can reasonably be expected to achieve their purpose;
- 3) For the purpose of utilization control, provided the services support members with ongoing or chronic conditions in a manner that reflects the member's ongoing need for such services and supports; or
- 4) Provided family planning services are provided in a manner that protects and enables the member's freedom to choose the method of family planning to be used.

Healthy Blue may exceed the service limits as specified in the Louisiana Medicaid State Plan provided those service limits can be exceeded, with authorization, in fee-for-service.

Appropriate limits may be placed on a service on the basis of medical necessity or for the purposes of utilization control (with the exception of Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) services), provided the services furnished can reasonably be expected to achieve their purpose in accordance with 42 CFR §438.210. No medically necessary service limitation can be more restrictive than those that currently exist under the Louisiana Medicaid State Plan including quantitative and non-quantitative treatment limits. Healthy Blue may limit services to those which are medically necessary and appropriate, and which conform to professionally accepted standards of care.

Healthy Blue shall use LDH's medical necessity definition as defined in LAC 50:I.1101 (Louisiana Register, Volume 37, Number 1) for medical necessity determinations, and make medical necessity determinations that are consistent with the State's definition. The Medicaid Director in consultation with the Medicaid Medical Director and Medicaid Behavioral Health Medical Director will make the final interpretation of any disputes about the medical necessity and continuation of core benefits and services based on whether or not the Medicaid fee-for-service program would have provided the service.

In addition to services covered under the Louisiana Medicaid State Plan, Healthy Blue may cover any services necessary for compliance with the requirements for parity in mental health and substance use disorder benefits in 42 CFR Part 438, Subpart K.

Healthy Blue shall comply with all court-ordered requirements of Chisholm v. Gee (refer to Prior

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Authorization Liaison (PAL) Policy – LA for Chisholm requirements) and the terms of the Louisiana Department of Justice (DOJ) Agreement (Case 3:18-cv-00608, Middle District of Louisiana) in the manner directed by LDH.

Healthy Blue shall provide pregnancy-related services that are necessary for the health of the pregnant woman and fetus, or that have become necessary as a result of being pregnant and includes but is not limited to prenatal care, delivery, postpartum care, and family planning services for pregnant women in accordance with 42 CFR Part 440, Subpart B.

Healthy Blue shall not avoid costs for services covered in its Contract by referring enrollees to publicly supported health care resources.

Healthy Blue shall not portray core benefits or services as a value-added benefit or service. Value-added benefits and services are not Medicaid-funded and, as such, are not subject to appeal and state fair hearing rights. A denial of these benefits will not be considered an adverse benefit determination for purposes of grievances and appeals. Healthy Blue shall send the member a notification letter if a value-added benefit or service is not approved.

Exceptions to utilization management requirements:

- Healthy Blue shall not require service authorization for emergency services or post-stabilization services as described in the Contract, whether provided by an in-network or out-of-network provider.
- 2) Healthy Blue shall not require service authorization or referral for EPSDT screening services.
- 3) Healthy Blue shall not require service authorization for the continuation of medically necessary covered services of a new member transitioning into the health plan, regardless of whether such services are provided by an in-network or out-of-network provider, however, prior authorization of services may be required beyond thirty (30) calendar days.
- 4) Healthy Blue is prohibited from denying prior authorization solely on the basis of the provider being an out-of-network provider for the first thirty (30) days of a newly enrolled member's linkage to the plan.
- 5) Healthy Blue shall not require a primary care physician (PCP) referral (if the PCP is not a women's health specialist) for access to a women's health specialist contracted with the plan for routine and preventive women's healthcare services and prenatal care.
- 6) Healthy Blue shall not require a PCP referral for in-network eye care and vision services.
- 7) Healthy Blue may require notification by the provider of obstetrical care at the time of the first visit of the pregnancy.
- 8) Healthy Blue shall not require hospital service authorization for non-emergency inpatient admissions for normal newborn deliveries.
- 9) Healthy Blue may require notification by the provider of obstetrical admissions exceeding forty-eight (48) hours after vaginal delivery. Healthy Blue is allowed to deny a portion of a claim for payment based solely on lack of notification by the provider of obstetrical

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admission exceeding forty-eight (48) hours after vaginal delivery. In this case, only the portion of the claim related to the inpatient stay beyond forty-eight (48) hours is denied.

- 10) Healthy Blue may require notification by the provider of obstetrical admissions exceeding ninety-six (96) hours after Caesarean section. Healthy Blue is allowed to deny a portion of a claim for payment based solely on lack of notification by the provider of obstetrical admission exceeding ninety-six (96) hours after Caesarean section. In this case, only the portion of the claim related to the inpatient stay beyond ninety-six (96) hours is denied.
- 11) Healthy Blue shall not deny continuation of higher level services (e.g., inpatient hospital) or residential treatment (e.g., therapeutic group home or psychiatric residential treatment facility) for failure to meet medical necessity unless it can provide the service through an innetwork or out-of-network provider for a lower level of care.

Refer to Non-Covered and Cost-Effective Alternative Services – LA for information regarding excluded, non-covered, and in lieu of services.

REFERENCES:

Administrative Denial Appeal Process - LA

Annual Audit of Health Plan Utilization Management Denial Files

Associates Performing Utilization Review - LA

Behavioral Health Member Appeals - Core Process

CFR Title 42 CFR §438

Center for Medicare and Medicaid Services Provider Preventable Conditions

Clinical Criteria for Utilization Management Decisions – Core Process

Clinical Information for Utilization Management Reviews – LACore Process

Concurrent Review (Telephonic and On-Site) - LA

Coverage for Post Stabilization Care Services

Denials

Emergency and Post-Stabilization Services - LACore Process

Extension Letters

Governance of Utilization Management Practice

Health Care Management Audit Policy - LA

Health Care Management Denial – Core Process

Informal Reconsideration – LA

HCM Precertification Process

Inpatient to Observation

Louisiana Healthy BlueState Contract

Member Appeals – Core Process – LA

NCQA Accreditation Standards and Guidelines: Appropriate Professional

NCQA Accreditation Standards and Guidelines: Timeliness of UM Decisions

NCQA Accreditation Standards and Guidelines: Clinical Information

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NCQA Accreditation Standards and Guidelines: Denial Notices

Non-Covered and Cost--Effective Alternative Services - LA

Observation - LADiversion

Out-of-Area, Out-of-Network Care - LA

Post Service Reviews (Retrospective)

Precertification of Requested Services – LACore Process

Prior Authorization Liaison (PAL) Policy – LA

Prohibiting the Use of Financial Incentives When Making Medical Necessity Determination

Provider Payment Appeal Process

Reconsideration/Re-open

Resolving Pended Claims and ActionGrams

Retrospective Review - LA

<u>Updating and Auditing Notice of Proposed Action Letters and Appeals review Forms</u>

Utilization Management - Criteria Disclosure

<u>Use of Board Certified Consultants (Medical/Behavioral Health) – Core Process</u>

Utilization Management Clinicians Responsibilities (Health Plan/Region)

Utilization Management - Medicaid Delegation and Oversight

WAC 284-43-410 - Utilization Review

RESPONSIBLE DEPARTMENTS:

Primary Department: ———Health Care Management — Utilization Management

Secondary Department(s):—Behavioral Health,

National Customer Care Organization,

Post Service Concurrent Review

Provider Services-Organization,

Quality Management

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REVISION HISTORY:

Review Date	Changes
04/23/2015	Create Louisiana-specific version
05/02/2016	For annual review
	Updated language under policy to read if "The LA HP" verses "If a plan"
	Definitions placed in alphabetical order
08/03/2017	For annual review
	Updated language to reflect Contract with Amendment 8
	DHH references changed to LDH
	References placed in alphabetical order

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	Claims removed as secondary department
	Departments placed in alphabetical order
07/26/2018	For annual review
	Primary Department updated
	Minor updates to procedure section with current contract language
08/01/2019	Annual Review
	Placed on updated template
	Updated Policy Section
	Updated Definitions
	Updated References
12/26/2019	Off cycle review;
	Revised for new LA Emergency Contract
	 Wells v. Gee Class Settlement terminated 10/24/2019
	• Policy title change from "Health Care Management Denial - Core
	Process – LA" to "Health Care Management Denial – LA"
	• Edits within policy, definition, procedure, exception, reference, and
	secondary department sections